STATE OF MAINE

DIRIGO HEALTH AGENCY

RE:	DETERMINATION OF AGGREGATE MEASURABLE COST SAVINGS FOR THE SECOND ASSESSMENT YEAR (2007)	))))	DECISION

I. INTRODUCTION

The Board of Directors of the Dirigo Health Agency (the "Board") is required to "determine annually not later than April 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M. R. S. A. § 6913 (1) (A). The Board's determination of aggregate measurable cost savings ("AMCS") is reviewed by the Superintendent of Insurance. 24-A M. R. S. A. § 6913 (1) (C). The determination of the Board is to be made after an opportunity for a hearing conducted in accordance with the Maine Administrative Procedure Act ("APA"). 5 M. R. S. A. §§ 9001-9064. The Board's determination of AMCS for the first assessment year (2006) was made on September 14, 2005, and filed with the Superintendent on September 19, 2005. After a two day adjudicatory hearing, the Superintendent rendered his decision on AMCS for the first assessment year on October 29, 2005. The Superintendent's decision is now on appeal before the Superior Court.

The Board's determination of AMCS for the second assessment year was made on May 12, 2006, following two days of hearings, May 8 and May 10, 2006. The Board determined that there were AMCS of $42,270,000.

II. PROCEDURAL HISTORY

The Board issued a Notice of Pending Proceeding and Hearing on January 27, 2006, which set a date for commencement of the hearing, made Dirigo Health a party to the proceedings and set the terms and conditions for intervention. The Maine Association of Health Plans ("MAHP"), the Maine State Chamber of Commerce (the "Chamber"), the Maine Automobile Dealers Association Insurance Trust (the "Trust"), Anthem Health Plans of Maine d/b/a Anthem Blue Cross and Blue Shield ("Anthem") and Consumers for Affordable Health Care ("Consumers") filed applications to intervene. In addition, the MAHP, the Chamber, Anthem and the Trust filed objections to the Notice of Pending Proceeding.

The Board issued Procedural Order No. 1 on February 13, 2006, setting the date for the exchange of witness lists and documents (March 3, 2006); designation of experts (March 3, 2006); identification of methodology and supporting data (March 8, 2006); filing of pre-filed testimony (March 10, 2006); pre-hearing briefs (March 14, 2006); and first session of public hearing (March 15, 2006).

On February 17, 2006, the Board issued an Order on Intervention and Response to Objections to Procedural Order No. 1. In its Order, the Board granted the applications for intervention of the Chamber, MAHP, Anthem and the Trust; granted a request that the presentation of alternative methodology be optional; and denied the request for discovery

on the basis that the APA does not require that there be an opportunity for discovery.[1] To the extent the parties sought information in the possession of Dirigo Health, the Board noted the availability of information under the Maine Freedom of Access Act ("FOAA"). In response to the concerns of the intervenors that the schedule for the proceedings was too compressed to afford them an opportunity to prepare a case, the Board noted the short time frames established by the Legislature, the participation of the intervenors in the proceedings before the Superintendent and the familiarity of the intervenors with the issues presented.

In further response to the objections of the intervenors, the Board, on February 22, 2006, issued an Amended Notice of Pending Proceeding and Hearing, which set March 27, 2006, for the first day of public hearings on AMCS; and Procedural Order No. 3, which changed the date for the exchange of witnesses and documents and designation of experts to March 10, 2006, the identification of methodology to March 13, 2006, pre-filed testimony to March 20, 2006, and pre-hearing briefs to March 24, 2006.

MAHP filed with Dirigo an extensive freedom of access request on February 24, 2006; Anthem filed a request on February 28, 2006; the Chamber filed a request on March 2, 2006; and the Trust filed a request on March 7, 2006. The requests all sought information regarding the methodology to be used by Dirigo Health in determining AMCS and the supporting data. A substantial portion of the information requested was in the possession of Dirigo Health's consultant, Mercer Government Human Services Consulting ("Mercer").

On March 7, 2006, Dirigo Health filed a motion to continue the hearing scheduled to begin on March 27, 2006, stating that relevant data need to calculate AMCS, including

[1] The Board granted the application of CAHC to intervene on March 6, 2006.

Medicare cost reports, would not be available until July 1, 2006. Dirigo Health also requested that the filing deadlines set forth in Board procedural orders be suspended. Dirigo Health notified the intervenors that it would not be providing information requested in their respective freedom of access requests pending a decision on the motion to continue. In addition, Dirigo Health did not file on March 10, 2006, as required by Procedural Order No. 3, its designation of witnesses and documents or its designation of expert witnesses; and did not by March 13, 2006 identify a methodology or supporting data. The Chamber, Anthem, the Trust and MAHP met these filing deadlines.[2]

James E. Smith, Esq., who had been appointed by the Board to serving as hearing officer, set March 13, 2006 for the filing of memorandum in support or in opposition to the motion to continue and March 14, 2006, for a hearing on the motion. The Chamber, Anthem, the Trust and MAHP filed memorandum opposing the motion to continue. Dirigo Health and CAHC filed a memorandum in support of the motion to continue. The hearing on March 14, 2006 was before the hearing officer. All parties presented oral argument on the motion to continue and were given the opportunity to address Dirigo Health's failure to produce documents in response to the freedom of access requests and Dirigo Health's failure to meet the filing deadlines in Procedural Order No. 3.

The hearing officer, with the agreement of the parties, directed Dirigo Health to produce documents in response to the freedom of access request on or before March 17, 2006 and to file its designation of witnesses and documents on or before March 17, 2006 and its methodology and data on or before March 20, 2006. All parties were ordered to file pre-filed testimony on or before March 22, 2006. Dirigo Health, on March 17, 2006, produced documents in its possession but not documents in the possession of Mercer.

[2] CACH also failed to meet the filing deadlines.

Despite requests by Dirigo Health and counsel for Dirigo Health, Mercer refused to produce documents in its possession unless served with a subpoena. Accordingly, the Board issued a subpoena on March 23, 2006, for documents with a return date of March 24, 2006. Mercer's counsel responded that it would need two weeks to produce the documents. On April 14, the Board directed the hearing officer to order Mercer to order Dirigo Health and Mercer to produce the documents forthwith. The hearing officer then issued an order on April 18, 2006 directing that the documents be produced no later than April 21, 2006.

The hearing officer, on March 20, 2006, issued a decision on Dirigo Health's motion to continue recommending that the motion be granted and provided the parties the opportunity to file written responses by March 24, 2006. On March 27, 2006 the Board met to deliberate on the motion to continue and the recommended decision. The Board voted 3-0 to adopt the recommended decision, which provided for a hearing not later than August 15, 2006. Anthem, the Chamber, MAHP and the Trust appealed the decision of the Board, pursuant to Rule 80C of the Maine Rules of Civil Procedure, to Superior Court. After briefing and oral argument, the Superior Court, on April 14, 2006, granted the appeal, remanded the matter back to the Board and ordered that the Board make a determination of AMCS no later than May 12, 2006.

On April 20, 2006, the hearing officer notified the parties that the public hearing on AMCS would commence on May 8, 2006 and continue on May 10, 2006. The hearing officer held a conference of counsel on April 27, 2006, to establish the order of proceedings. At the conference, the hearing officer denied the motion of Anthem to strike the methodology proposed by CAHC; ordered Dirigo Health to produce

supplemental witness testimony by May 1, 2006; and, ordered Mercer (Dirigo Health) to supplement its March 20, 2006, report on AMCS by May 2, 2006, and include with the supplement its calculations and all documents considered, reviewed, or relied upon for the report.

On May 7, 2006, MAHP filed a motion requesting that the Board strike the supplemental testimony of Stephen P. Schramm of Mercer and strike the supplemental Mercer report. The reason for the request was the failure of Dirigo Health to produce the documents that were used by Mercer in calculating AMCS on May 2, 2006, as ordered by the hearing officer. In particular, Dirigo Health did not produce the Medicare cost reports used in calculating cost per Case Mixed Adjusted Discharge. Dirigo Health responded that it provided Mercer's supplemental report on May 2, 2006 along with supporting spreadsheets and source documentation; that it provided electronically Medicare cost reports for fiscal year 2005 on May 3, 2006; and that it discovered on May 4, 2006, that it had inadvertently not provided Medicare cost reports for fiscal years 1999 -2000. Counsel for Dirigo Health notified intervenors of this oversight on May 4 and provided the reports to intervenors on May 5, 2006.[3] The Board did not rule on MAHP's motion prior to the commencement of the hearing on AMCS on May 8, 2006.

III. ADJUDICATORY HEARING

A. Procedure

The proceedings in this matter were conducted in accordance with the requirements of the APA. Prior to the start of the public hearing on May 8, 2006, the

[3] The Board notes that the Medicare cost reports for 1999-2000 were included in the record of proceedings before the Superintendent for the first assessment year.

parties were requested to exchange witness lists and documents, including a summary of the testimony of each witness; to designate expert witnesses, including information required to be disclosed under Rule 26 (b) 9(4) (A), M. R. Civ. P.; to submit pre-filed testimony; and to submit pre-hearing briefs. The parties were given the opportunity to identify a methodology for determining AMCS and to include supporting data. The Board denied the request of MAHP, the Chamber, the Trust and Anthem for additional discovery, but noted that the intervenors could request information from Dirigo Health pursuant to the FOAA. Attorney James E. Smith served as hearing officer for the proceeding.

The Board is made up of five voting members and three non-voting members. Charlene Rydell, a voting member, was unable to participate in the proceedings. Dana Connors, another voting member, recused himself from the proceedings. Two of the non-voting members, Trish Riley, Director of the Governor's Office of Health Policy and Finance, and Rebecca Wyke, Commissioner of the Department of Administrative and Financial Services, recused themselves from the evidentiary portion of the hearing and from deliberations on AMCS. The third non-voting member, Lloyd Fountain, Acting Commissioner of the Department of Professional and Financial Regulation, participated in the evidentiary portion of the hearing and in deliberations, but did not vote. Board members participating in the hearing and voting were Ned McCann, Jonathan Beal and Robert McAfee, M. D.

The Board received evidence on May 8 and May 10, 2006. The Board deliberated and rendered a decision on the record on May 12, 2006. Dirigo Health, MAHP, the Chamber and Anthem presented testimonial and documentary evidence at the hearing.

The Trust offered documentary evidence but did not present any witnesses. CAHC submitted pre-filed testimony of one witness, but withdrew the testimony. CAHC offered documentary evidence. All parties were given the opportunity and undertook direct and cross-examination of the witnesses. In addition, Board members asked questions of the witnesses.

B. Legal Issues

1. Savings included in AMCS

As a preliminary matter, MAHP, the Chamber, the Trust and Anthem raise the issue: What savings are to be included in AMCS? They argue that the only savings to be included are savings from a reduction or avoidance of bad debt and charity care and any increased MaineCare enrollment due to an expansion of MaineCare eligibility, citing 24-A M. R. S. A. § 6913 (1) (C). Dirigo Health and CAHC argue that AMCS includes savings from any reduction or avoidance of bad debt and charity care and increased MaineCare enrollment; and, in addition, savings from other government initiatives. The thrust of the arguments of MAHP, the Chamber, the Trust and Anthem is that savings must result from the operation of Dirigo Health and that the only such savings are from the reduction of bad debt and charity care and increased MaineCare enrollment. Dirigo Health and CAHC respond that AMCS includes savings that have resulted from, the so-called, Health Care Reform Act, P. L. 2003, ch. 469, as amended by P. L. 2005, ch. 400, and are not limited to bad debt and charity care and increased MaineCare enrollment.

The Board is not persuaded that AMCS is limited to savings from any reduction or avoidance of bad debt and charity and increased MaineCare enrollment. Regardless of what certain individual legislators may have thought about how the Dirigo Health

Program was to operate and be financed, the law, as enacted, in the Board's view, does not limit AMCS to those savings initiatives. Section 6913 only states that savings are to include any reduction or avoidance of bad debt and charity care as a result of the operation of Dirigo Health and increased MaineCare enrollment; it neither limits savings to these initiatives nor expressly states what other initiatives may be considered by the Board in making a determination of AMCS. In any event, the Board does not deem it necessary to decide conclusively what initiatives may or may not be included in AMCS in order to make a determination of AMCS for the second assessment year. It need only decide whether the initiatives presented by Dirigo Health for the second assessment year should be included.

2. Admission of Medicare Cost Reports and Testimony of Mr. Schramm.

As indicated above, MAHP filed a motion of May 7, 2006 requesting that the Board exclude those portions of the May 1, 2006, Pre-filed Testimony of Dirigo Health consultant Stephen P. Schramm, and those portions of the May 2, 2006, Supplemental Report of Mercer, related to proposed Hospital Savings Initiatives (CMAD). The basis of the motion was that the MAHP, the Chamber, the Trust and Anthem had been prejudiced in their preparation for the hearing by the failure of Dirigo Health to timely respond to the freedom of access requests submitted by MAHP, the Chamber, Anthem and the Trust; to comply with the Board's procedural orders on the designation of witnesses and exchange of documents; and the delay until May 5, 2006 in the production of the Medicare cost reports used in the calculation of CMAD.

On May 8, 2006, Dirigo Health presented Mr. Schramm as a witness on CMAD and offered into evidence DHA Exhibit # 4, Medicare cost reports. MAHP, the Chamber,

the Trust and Anthem objected to the admission of DHA Exhibit # 4 for the reasons set forth in the May 7 motion of MAHP. They also objected to admission of the testimony of Leonard Brauner, a witness for Dirigo Health. In addition, Anthem noted that it was unclear exactly what documents were included in DHA Exhibit # 4; and through the testimony of Mr. Schramm it appeared that a substantial portion of the documents had been in the possession of Mercer at the time the freedom of access requests had been submitted. It also appeared from the testimony of Mr. Schramm that the bulk of the documents in DHA Exhibit # 4 were provided as part of the record in the first assessment year proceedings before the Superintendent; that Mercer's March 20 report identified the methodology to be used and the source of the information; and that the Medicare cost reports were publicly available. Counsel for the Chamber noted that there are more than one form of Medicare cost reports and that any analysis of Mercer's methodology and calculations required that all parties be looking at the same Medicare cost reports.

After meeting with counsel for the Board in executive session, the Board took further testimony of Mr. Schramm on the documents in DHA Exhibit # 4 and reserved a ruling on the objection to admission of the exhibit. From the testimony and arguments presented, it appeared that Dirigo Health had produced Medicare cost reports for 1999-2004 and some, if not all, available reports for 2005. Counsel for Dirigo Health stated she would provide to all parties a complete set of the reports for 2005 that Mercer used in its calculations at the end of the hearing. In order to give the parties the opportunity to review all the reports used by Mercer, the Board ordered that Mr. Schramm's testimony on CMAD be suspended for the day and that he be made available to testify on CMAD on May 10, 2005.

C. Determination of AMCS

In Procedural Order No. 2, the Board asked that any party intending to propose a methodology to determine AMCS provide a detailed description of the methodology and submit supporting data. Dirigo Health, MAHC and Anthem proposed methodologies in their pre-filed testimony and documents. The Chamber proposed an alternative methodology through the testimony of Mr. John Sheils and documents admitted into evidence during the hearing.

Anthem presented a methodology for calculating savings in the expense per CMAD. This methodology included the development of a corridor for each hospital that represented the normal range of fluctuations in hospital expenses over a base period. If the expense per CMAD in the assessment year exceeded the upper limits of the corridor, there would be no savings. If the expense was less than the lower limits of the corridor, there might be savings. An examination would then be undertaken to try to establish the reason for the expense to be outside the normal range of expected fluctuations, such as a major change in volume. If the cost fell within the corridor, there would be no savings since the expense was within the normal range of fluctuations. After due consideration of the testimony on the corridor method, the Board decided not to adopt this method for calculating CMAD because it did not adequately account for the wide variety of data included in the Mercer and Sheils methodology and did not take into account the effect of outlying data points in the calculation.

The MAHP methodology focused on the calculation of savings from any reduction or avoidance of bad debt and charity and adopted the criticisms of Mr. Sheils

with regard to the Mercer methodology. It is only in this respect that MAHP was offering an alternative methodology.

Mr. Sheils' methodology related to CMAD. Through presentation of a number of charts, and using figures developed by Mercer, he undertook to demonstrate the impact on the calculation of savings by expanding the base line to include experience over a four-year (1999-2003) rather than the three-year period used by Mercer (2000-2003), the impact of measuring savings using 2004 as the base line and the impact of decreasing the projected rate of growth. The Board incorporated, in part, the approach of Mr. Sheils in determining AMCS as will be discussed below.

Dirigo Health presented a methodology for calculating savings for four savings initiatives: Hospital Savings Initiatives (CMAD), Uninsured Savings Initiatives (Bad Debt and Charity Care, MaineCare Adult Expansion and Woodwork Effect Savings), Certificate of Need and Capital Investment Fund (CON/CIF) and Health Care Provider Fee Savings Initiatives. Except for CON/CIF, Dirigo Health used as a starting point for each initiative the methodology presented to the Superintendent for the first assessment year adjusted to address concerns raised by the Superintendent in his decision. The Board adopted, in part, the Dirigo Health methodology for calculating ACMS as discussed below.

1. Hospital Savings Initiatives (CMAD)

Before reaching the issue of the calculation of savings from CMAD, the Board addressed the question whether CMAD should be included in AMCS. The Chamber, Anthem, the Trust and MAHP objected to the inclusion of savings from CMAD because any savings were the result of voluntary efforts of hospitals and not the result of the

operation of Dirigo Health. In addition, they argued that, even if appropriately included in savings for the first assessment year because P. L. 2003, ch. 469 asked the hospitals to limit growth in CMAD for SFY 2004 , the savings should not be included in the second assessment year because there is no statutory support for SFY 2005 voluntary savings.[4] Dirigo Health argued that savings from CMAD for the second assessment year was a continuing effort under the Health Care Reform Act and demonstrated through cross examination of Steven Michaud, President Maine Hospital Association, that voluntary savings from CMAD for SFY 2005 were considered part of government initiated health care reform. After consideration of the evidence and testimony, and the arguments of the parties, the Board was persuaded that savings from CMAD for the second assessment year were influenced by the Health Care Reform Act, commonly referred to as the Dirigo initiative, and are appropriately included in AMCS for the second assessment year.

The calculation of savings from CMAD were made by Mercer and offered by Dirigo Health through the testimony of Mr. Schramm. Mr. Schramm and the Mercer Report (Schramm Exhibits 2 and 3) explained, and the Board takes notice of the fact, that the data is incomplete with regard to the calculation of savings from CMAD and that the calculation is preliminary. The Mercer methodology for the second assessment year blended hospital revenues and expenses to determine state-wide revenues and expenses to calculate state-wide CMAD figures for SFYs 2000-2003 and 2005. Mercer, using a base period of 2000-2003, then essentially compared expected growth in CMAD from 2003 to 2005 with actual growth and used the difference to calculate savings in CMAD. The

[4] The Legislature again asked the hospitals to voluntarily restrain cost increases (and consolidated operating margins) for hospital fiscal years beginning on or after July 1, 2005 and remaining in effect through the end of each hospital's fiscal year beginning on or after July 1, 2007. P. L. 2005, ch. 394.

methodology and calculations are set forth in Schramm Exhibits 2 and 3. Using its methodology, Mercer calculated savings of $72.7 million.

Anthem, the Chamber, the Trust and MAHP, through the testimony of Mr. Sheils and Roland Mercier, pointed out that CMAD is sensitive to a wide variety of factors, including fluctuations in patient volume, patient mix, payor mix, Medicaid reimbursement rates, operating margins and hospital trends, and argued that the Mercer methodology does not take into account these and other important factors. The Board felt that Mercer took a reasonable and conservative approach in making assumptions with regard to volume and trends used in its calculations. The Board carefully considered the issues raised and was particularly concerned with the significant impact a change in volume can have on CMAD and the aggressive growth rate used by Mercer in its calculations. This growth rate, in part, is the product of the 10.1 percent increase in CMAD in the 2002, one of the base years. The Board accepted the approach outlined in Mr. Sheils' testimony, which developed a far more conservative calculation of savings from CMAD by application of Mercer's three year base period to determine a median growth rate and using the median growth rate to project growth in 2005.

After consideration of the testimony and documentary evidence, the Board voted 3-0 to adopt the Mercer methodology but to calculate savings using a more conservative growth rate of 4.7% as demonstrated in Chamber Exhibit # 21, Table 7. This results in savings of $14.5 million from CMAD.[5]

2. Uninsured Savings Initiatives

[5] The Board's determination of savings from CMAD is based on available data and recognizes that there may be additional data available to include in the calculation when the Superintendent of Insurance undertakes his review of the Board's determination.

All parties agree that savings from a reduction or avoidance of bad debt and charity care and from increased enrollment in MaineCare as a result of an expansion in MaineCare eligibility for adults are to be included in AMCS. There is disagreement, however, over the methodology. Anthem, the Chamber, the Trust and MAHP object to the methodology for a number of reasons, including failure to consider that 50 percent of hospital care is provided to patients paid for through government programs; failure to consider the "crowd out" effect of increasing government program expansion; failure to verify actual savings in 2004 against projected savings; failure to analyze the distribution of DirigoChoice members over the various deductible levels; and failure to determine the deductible levels of the previously insured. In addition, they argue it is unreasonable to assume that 100% of savings are passed on to the payors and to ignore the fact that there is a loss of revenue when a person moves from private insurance to MaineCare.

a. Bad debt and Charity Care (BD/CC)

Mercer calculated savings from a reduction in BD/CC by determining the costs attributable to previously uninsured and underinsured individuals that are now enrolled in DirigoChoice using available data from Dirigo Health, and data from hospitals and other care providers. The data was then put on a consistent CY basis and adjusted from a charge to a cost basis. From the data, Mercer calculated a per member per month (PMPM) cost. After adjusting for claims probability distribution, Mercer multiplied the PMPM by estimated member months (MM) to arrive at savings. The methodology is set forth in Schramm Exhibit # 2; the calculations are in Schramm Exhibit # 3. The Board considered the objections outlined above and concluded that the methodology took them into account and that Mercer had erred on the conservative side in making its

assumptions. The Board voted 3-0 to include in AMCS savings in the amount of $2.7 million from reductions in BD/CC.

b. MaineCare Adult Expansion

For the MaineCare Adult Expansion, Mercer used the PMPM and MM months as calculated for the uninsured and underinsured, adjusted for cost-sharing differences and differences in assumed future BD/CC expenditures and then calculated savings as set forth in Schramm Exhibit # 3. The Board voted 3-0 to include in AMCS savings in the amount of $3.9 million from MaineCare adult expansion, after consideration of the objections outlined above and the conservative assumptions made by Mercer.

c. Woodwork Effect

The "woodwork effect" is the phenomena that the publicity accompanying the launching of a new health care initiative, such as the Dirigo Program, results in the enrollment in health care coverage of persons who would otherwise not seek coverage. Mercer calculated the "woodwork effect" of the Dirigo Program by counting the number of persons who applied for coverage under DirigoChoice and were found to be eligible for MaineCare. Mercer looked at enrollment from July 2005 to December 2006, using actual numbers where available and estimating future months, but assuming no growth from the most recent enrollment figures. The Board voted 3-0 to include savings in the amount of $57,000 for the second assessment year.

3. Certificate of Need and Capital Investment Fund Initiatives (CON/CIF)

Dirigo Health proposed to include in AMCS savings from hospitals that withdrew or revised applications for a CON in order to bring the projects under the $400,000 threshold for review by the Department of Health and Human Services (DHHS) and

savings resulting from current CIF limitations on the number of projects that can be approved. For the CIF savings, Mercer determined the combination of possible approvals that would produce the lowest savings amount. Anthem, the Chamber, the Trust and MAHP objected to the inclusion of savings from CON/CIF because they are not the result of the operation of Dirigo Health; and the calculations because Mercer did not evaluate and verify the reasons a project was withdrawn and whether any costs had actually been incurred. Furthermore, it was pointed out that no consideration had been given to the fact that the costs incurred for approved projects would show up in CMAD in the years of construction.

The Board voted 3-0 to include CON/CIF in AMCS for the second assessment year. The Board considered the objections raised, but also noted the absence of any evidence contradicting the assumptions utilized by Mercer, including the absence of any testimony from Steven Michaud of the MHA or any of the affected hospitals contradicting those assumptions. The Board determined that the limits imposed on capital expenditures as a result of the Health Care Reform Act were a critical part of the State's effort to contain the growth of health care expenditures and that the issue of hospital expansion was an important consideration in development of the State Health Plan. With regard to Mercer's methodology, the Board found Mercer's approach very conservative and alluded to the fact that Mercer did not include in its analysis non-hospital large projects, hospital small projects or non-hospital small projects and that none of the witnesses contradicted the assumptions used by Mercer. The Board voted 3-0 to include the amount of $5.4 million in AMCS for the second assessment year.

4. Health Care Provider Fee Initiatives

The Health Care Provider Fee Initiatives seek to capture savings from a reduction in the need for cost shifting as a result of the infusion of additional money into the health care system. Dirigo Health argues that these initiatives—increase in Prospective Interim Payments (PIP) to hospitals and increased physician payments—are linked to the Health Care Reform Act, which established the Hospital Study Commission. The Commission recommended that the legislature take action with regard to past shortfalls in Medicaid reimbursement rates and the increased cost to physicians of providing access the MaineCare patients. Anthem, the Chamber, the Trust and MAHP objected to the inclusion of the fee initiatives in AMCS because the Medicaid program is the responsibility of DHHS, not Dirigo Health. With regard to PIP and other payments to hospitals, they argued that these initiatives were the result of the settlement of litigation and related administrative proceedings initiated to recover amounts due the hospitals and not the result of the Health Care Reform Act. They also challenged the methodology as unreasonable because it did not account for the impact of the hospital tax, the continued shortfall in Medicaid reimbursement rates, delays in Medicaid payments and the fact that if physicians must return the payments to Dirigo Health through savings offset payments they will have to continue to shift costs to insured patients.

The Board voted 3-0 to include the fee initiatives in AMCS for the second assessment year. The Board noted the testimony of Commissioner Wyke with regard to the reasons for the hospital settlement, the increased PIP payments and the increase in physician fees; the testimony of Mr. Schramm that Mercer had taken into account the hospital tax; and the Hospital Study Commission's recommendations leading to the fee

initiatives. The Board thus determined that fee initiatives were linked to the Health Care Reform Act.

The methodology and calculations made by Mercer are set forth in Schramm Exhibit # 2 and Schramm Exhibit #3. The savings amount of $15.2 million dollars was the sum of the time value of early receipt of PIP payments, and the additional payments to physicians. The Board voted 3-0 to include savings in the amount of $15.2 million from the fee initiatives in AMCS for the second assessment year.

IV. CONCLUSION

Based upon the evidence presented, the Board has determined AMCS in the amount of $42,270,000 for the second assessment year. This amount is comprised of: CMAD--$14.5 million; BD/CC--$2.7 million; MaineCare Adult Expansion--$3.9 million; Woodwork Effect--$57,000; CON/CIF—$5.4 million; Health Care Provider Fee Initiatives--$15.2 million.

Dated: June 6, 2006

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Robert A. McAfee, M. D.

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Jonathan S. R. Beal, Esq.

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RIGHTS OF APPEAL

To the extent that an appeal is authorized, any party may appeal this Decision to Superior Court, in accordance with 5 M. R. S. A. § 11001, et seq. and M. R. Civ. P. 80C, by filing a petition for review within 30 days of the date of receipt of the Decision. Any other person aggrieved by this Decision, to the extent an appeal is authorized, may petition for review by the Superior Court by filing a petition with 40 days from the date of the Decision.